1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3426

CERTIFICATE OF DEATH

03378

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Rock Hall
c. LENGTH OF STAY IN 1b: adult life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: At Home - Piney Neck

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural - Rock Hall
d. STREET ADDRESS: Piney Neck
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bernice — Middle: B. — Last: Ashley

4. DATE OF DEATH: Month: Mar. — Day: 14, — Year: 1960

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9/7/1870

9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: retired

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William A. Baldwin

14. MOTHER'S MAIDEN NAME: Martha Swindells

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

INFORMANT: Bernice Edwards — Address: Rock Hall, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema
422.1
DUE TO (b): Cardio Vascular
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Arteriosclerosis (Senility)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1 1955 to March 14 1960, that I last saw the deceased alive on March 14 1960, and that death occurred at 10P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Norbert C Nitsch M.D.
ADDRESS (Street, city or town, state): Rock Hall, Maryland
DATE SIGNED: 3/15/60

PHYSICIAN'S NAME (Type): Norbert C. Nitsch

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/18/60
22c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel Cem.
22d. LOCATION (City, town, or county) (State): Nr. Rock Hall, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J Willis Wells
ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: MAR 17 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3415 — Reg. Dist. No. 03379

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Kent & Queen Anne's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Kennedyville
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Ethel — Middle: S. — Last: Black

4. DATE OF DEATH: Month: 3 — Day: 28 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/2/89

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Indiana

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Oscar Spurgin

14. MOTHER'S MAIDEN NAME: Bell Reynolds

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 218-20-9205

INFORMANT: Ethel S. Black — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure. — INTERVAL BETWEEN ONSET AND DEATH: 1 WK.
DUE TO (b): Right Sim Heart Failure — years.
DUE TO (c): Mitral Disease. — years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 434.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/22, 1960 to 3/25, 1960, that I last saw the deceased alive on 3/28, 1960, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas J Solon — M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED:

PHYSICIAN'S NAME (Type): Thomas J. Solon — Chestertown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/31/60
22c. NAME OF CEMETERY OR CREMATORY: St. Paul Cemetery
22d. LOCATION (City, town, or county) (State): near Fairlee Kent Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Marvin V. Williams — ADDRESS: Marvin V. Williams Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: APR 1 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3416

CERTIFICATE OF DEATH

03380

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Anne Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X near Chestertown,
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First JAMES — Middle LOEN — Last BLACK

4. DATE OF DEATH: Month March — Day 2 — Year 1960

5. SEX: male

6. COLOR OR RACE: colored

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 1/12/60

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months 1 — Days 19 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Kent Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Black

14. MOTHER'S MAIDEN NAME: Fredia Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

INFORMANT: Hospital Records — Address: Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Extreme dehydration and electrolyte loss — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b): Diarrhea or Enteritis, cause unknown — 5 days
DUE TO (c):

571.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/12/60, 19__, to 3/2/60, 19__, that I last saw the deceased alive on 3/2/60, 1960, and that death occurred at 1:20A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert W. Farr, M.D. — ADDRESS (Street, city or town, state): Chestertown Md — DATE SIGNED: 3/2/1960

PHYSICIAN'S NAME (Type): ROBERT W. FARR

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 3/2/60 — 22c. NAME OF CEMETERY OR CREMATORY: Coleman Cem. — 22d. LOCATION (City, town, or county) (State): RFD Worton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Kenneth Walker — ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR — DATE: MAR 3 '60

24b. REGISTRAR'S SIGNATURE: Elvina L. Frame

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

Form 4/5/60

2072162 XV 4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03381

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Massey
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Massey
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALBERT Middle L. Last CUMMERFORD

4. DATE OF DEATH: Month March Day 3 Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May, 17, 1890
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic. Boat Yard
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Cummerford
14. MOTHER'S MAIDEN NAME: Katherine Dixon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 217-03-3572
17. INFORMANT: Willis Cummerford, Address: Millington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Heart attack (acute) — INTERVAL BETWEEN ONSET AND DEATH: sudden

434.4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Chronic heart decompensation — 6 years
DUE TO (c): Diabetes mellitus — 4 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 22, 1959, to March 3, 1960, that I last saw the deceased alive on Feb. 16, 1960, and that death occurred at 4:15 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Alex Koralewski M.D.
ADDRESS (Street, city or town, state): MILLINGTON MD
DATE SIGNED: 3.4.60

PHYSICIAN'S NAME (Type): ALEXA KORALEWSKI * March 3. 60.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 6, 1960
22c. NAME OF CEMETERY OR CREMATORY: Massey Cemetery
22d. LOCATION (City, town, or county) (State): Massey, Kent Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward F. Manns ADDRESS: Millington, Md.
24a. REC'D BY REGISTRAR DATE: MAR 8 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3428 **CERTIFICATE OF DEATH** 03382

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETTERTON
c. LENGTH OF STAY IN 1b: 20
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BETTERTON
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CATHERINE Middle MAY Last DEDMAN

4. DATE OF DEATH: Month March Day 22 Year 1960

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: FEB 3, 1876

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NURSE

10b. KIND OF BUSINESS OR INDUSTRY: VET. ADMIN.

11. BIRTHPLACE (State or foreign country): BETTERTON Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: EBEN WELSH CREW

14. MOTHER'S MAIDEN NAME: LAURA ALEXANDRIA ~~LOUISE~~ OWENS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WWI

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: LOLLA O. CREW Address: BETTERTON, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral vascular accidents — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO (b): arteriosclerosis — 10 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): moderate hypertension

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 1, 1953, to Mar, 1960, that I last saw the deceased alive on March 19, 1960, and that death occurred at 9 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Florence Deringer Joyce M.D. ADDRESS (Street, city or town, state): WORTON, Md DATE SIGNED: 3-22-60

PHYSICIAN'S NAME (Type): Florence Deringer Joyce Worton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-25-60

22c. NAME OF CEMETERY OR CREMATORY: Still Pond Cemty

22d. LOCATION (City, town, or county) (State): Still Pond, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Victor N. Kennedy ADDRESS: Still Pond, Md.

24a. REC'D BY REGISTRAR DATE: MAR 24 '60

24b. REGISTRAR'S SIGNATURE: Arlene S. Kane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03383

3417 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Ann's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Millington
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Thelma — Middle: Luverne — Last: Gillum

4. DATE OF DEATH: Month: March — Day: 13 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 25, 1916

9. AGE (In years last birthday): 43 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Percy Hite

14. MOTHER'S MAIDEN NAME: Lola Boor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

INFORMANT — Address: Hospital records, Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Metastatic carcinoma of the liver — INTERVAL BETWEEN ONSET AND DEATH: 5 months

156.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 1-6, 1960, to 3-13, 1960, that I last saw the deceased alive on 3-13, 1960, and that death occurred at 9:50 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: A.C. Dick M.D. — ADDRESS (Street, city or town, state): Chestertown, Md. — DATE SIGNED: 3-13-60

PHYSICIAN'S NAME (Type): A.C. Dick, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 17, 1960
22c. NAME OF CEMETERY OR CREMATORY: Millington Cemetery
22d. LOCATION (City, town, or county) (State): Millington, Kent Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward S. Wilson's — ADDRESS: Millington Md.

24a. REC'D BY REGISTRAR — DATE: MAR 17 '60

24b. REGISTRAR'S SIGNATURE: Arthur J. Kuhns

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3418 **CERTIFICATE OF DEATH** 4614

1 PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Anne Hosp.

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 27 Chestertown
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ X

3. NAME OF DECEASED (Type or print): First Eugene Middle C. Last Gland
4. DATE OF DEATH: Month Mar. Day 31, Year 1960
5. SEX: male
6. COLOR OR RACE: colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3/6/1897
9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: various
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Douglas Gland
14. MOTHER'S MAIDEN NAME: Laura Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW 1
16. SOCIAL SECURITY NO.: 220-12-2244
17. INFORMANT: Violet Gland Address: 124 Cross St. Chestertown, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 4 Days
DUE TO (b): Hypertension + Pneumonia — 7 years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pneumonia + Pyelitis — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/28, 1960, to 3/31, 1960, that (I) (we) last saw the deceased alive on 3/31, 1960, and that death occurred at 6:30 P M, from the causes and on the date stated above.

22a. SIGNATURE: Thomas J. Solon M.D
ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 3/31/60
22c. PHYSICIAN'S NAME (Type): Thomas J. Solon
22d. ADDRESS: Chestertown, Md.

23a. BURIAL CREMATION REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/4/60
23c. NAME OF CEMETERY OR CREMATORY: Janes Cem.
23d. LOCATION (City, town, or county) (State): Chestertown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Kenneth Waller ADDRESS: Chestertown, Md.
25a. REC'D BY REGISTRAR DATE: APR 6 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3419 CERTIFICATE OF DEATH

Reg. Dist. No. 03384

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Anne's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Queen Anne's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Church Hill
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

17X-2

072

3. NAME OF DECEASED (Type or print): First Frank; Middle Covington; Last Green

4. DATE OF DEATH: Month 3; Day 28; Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2/4/83

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Green

14. MOTHER'S MAIDEN NAME: Mary Elizabeth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213 12 5447

INFORMANT Address: Eleanor Dixon, daughter

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 3-4 days

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b): Congestive heart failure — 4 years

DUE TO (c): Arteriosclerotic heart disease — years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 3-28 27, 1960, to 3-28, 1960, that I last saw the deceased alive on 3-28-60, 19, and that death occurred at 9: PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Harry Paul Ross M.D.

ADDRESS (Street, city or town, state): 203 N. Queen St, Chestertown, Maryland

DATE SIGNED: 3-29-60

PHYSICIAN'S NAME (Type): HARRY PAUL ROSS, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 3/31/60

22c. NAME OF CEMETERY OR CREMATORY: Church Hill

22d. LOCATION (City, town, or county) (State): Church Hill Md

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L Jones

ADDRESS: Church Hill, Md.

24a. REC'D BY REGISTRAR DATE APR 5 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03385

3429 CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Kent — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Chestertown
c. LENGTH OF STAY IN 1b: 30 yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural - Chestertown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: at home

d. STREET ADDRESS: /

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Joseph Middle Gsell Last

4. DATE OF DEATH: Month March Day 18, Year 1960

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar. 17, 1869

9. AGE (In years last birthday): 91 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: owner

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? USA (Nat)

13. FATHER'S NAME: Don't Know

14. MOTHER'S MAIDEN NAME: Don't Know

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

INFORMANT: W. Henry Gsell Address: Chestertown, Md. Son

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Pulmonary Oedema — INTERVAL BETWEEN ONSET AND DEATH

423.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cardiac Insufficiency

DUE TO (c): Arteriosclerosis (Senility)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1, 19 60, to March 19 60, that I last saw the deceased alive on March 19, 19 60, and that death occurred at 6 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Norbert C. Natsch M.D.

ADDRESS (Street, city or town, state): Rock Hall

DATE SIGNED: 3/20/60

PHYSICIAN'S NAME (Type): Norbert C. Natsch Rock Hall, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Mar. 21, 1960

22c NAME OF CEMETERY OR CREMATORY: Greensboro Cem.

22d. LOCATION (City, town, or county) (State): Greensboro, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: MAR 22 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3420

03386 Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN
c. LENGTH OF STAY IN 1b: 14 HRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: KENT-QUEEN ANNE'S HOSP

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Queen Anne's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SUDLERSVILLE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle RAYFIELD Last JARRELL

4. DATE OF DEATH: Month MAR Day 23 Year 1960

5 SEX: M

6 COLOR OR RACE: W.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: NOV 24, 1877

9. AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMING

10b KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES JARRELL

14 MOTHER'S MAIDEN NAME: MARY CATHERINE BUSTEED

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): UNK (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT: HOSPITAL CHART Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): INTESTINAL OBSTRUCTION & GANGRENE — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS

570.2

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ARTERIOSCLEROTIC HEART DISEASE

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from MAR 22, 1960, to MAR 23, 19__, that I last saw the deceased alive on MAR 23, 1960, and that death occurred at 2:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: C. J. Keefe, M.D. ADDRESS (Street, city or town, state): CHESTERTOWN, Md. DATE SIGNED: 3/28/60

PHYSICIAN'S NAME (Type): ARTHUR T. KEEFE, JR. MD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: MAR. 26, 1960

22c. NAME OF CEMETERY OR CREMATORY: CHESTERFIELD CEM.

22d. LOCATION (City, town, or county): CENTREVILLE (State): MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Fellows ADDRESS: Millington, Md.

24a REC'D BY REGISTRAR DATE: MAR 28 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03387

3421

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Kent — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown

c. LENGTH OF STAY IN 1b: life

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Anne Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall

d. STREET ADDRESS: Rt #1

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Otis — Middle: Lee — Last: Johnson

4. DATE OF DEATH: Month: 3 — Day: 28 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-28-60

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours: 1 — Min: 40

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Chestertown - Md.

12. CITIZEN OF WHAT COUNTRY?

13 FATHER'S NAME: Wakefield Joseph Johnson

14. MOTHER'S MAIDEN NAME: Mary Louise Lisco

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fetal Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 40 / 1 hour 40
762.5
DUE TO
(b): Prematurity. — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/28/60, 19__, to 3/28, 1960 that I last saw the deceased alive on 3/28, 19 60, and that death occurred at ____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas J. Solon, M.D. — ADDRESS (Street, city or town, state): Chestertown, Md. — DATE SIGNED: 3/28/60

PHYSICIAN'S NAME (Type): Thomas J. Solon

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/29/60

22c. NAME OF CEMETERY OR CREMATORY: Sharptown Col. Cem.

22d. LOCATION (City, town, or county) (State): nr. Rock Hall, Md.

23 FUNERAL DIRECTOR'S SIGNATURE: Kenneth Walker — ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: MAR 31 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

2072-32-XVO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3430 **CERTIFICATE OF DEATH**

Reg. Dist. No. 03388

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 to be retained by the hospital or attending physician. GENERAL DIRECTIONS: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Massey
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Massey X
d. STREET ADDRESS /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANDREW Middle WOODALL Last JONES

4. DATE OF DEATH: Month March Day 3 Year 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 24, 1881

9. AGE (In years last birthday): 78 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Feed and Grain Dealer

10b. KIND OF BUSINESS OR INDUSTRY: Retailer

11. BIRTHPLACE (State or foreign country): Cecilton, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas T. Jones

14. MOTHER'S MAIDEN NAME: Rachel E. Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-18-5947A

17. INFORMANT: Julian H. Jones, Address: Massey, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO (b): Cerebral Arteriosclerosis. — years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 2, 19 60 to 3 Mar, 19 60, that I last saw the deceased alive on 3 Mar, 19 60, and that death occurred at 8:15 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wallace Oberndorfer M.D. ADDRESS (Street, city or town, state): Cecilton, Md DATE SIGNED: 7 Mar 60

PHYSICIAN'S NAME (Type): WALLACE OBERNDORFER

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March 7, 1960

22c. NAME OF CEMETERY OR CREMATORY: Cecilton Cemetery

22d. LOCATION (City, town, or county) (State): Cecilton, Cecil Co; Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Fallon — ADDRESS: Middletown, Del.

24a. REC'D BY REGISTRAR DATE MAR 9 '60

24b. REGISTRAR'S SIGNATURE: Clara S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3431 **CERTIFICATE OF DEATH** Reg. Dist. No. 03389

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, s 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millington
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Joseph Middle T. Last Jones

4. DATE OF DEATH: Month March Day 5, Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 1, 1895
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10b. KIND OF BUSINESS OR INDUSTRY: Painting
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William C. Jones
14. MOTHER'S MAIDEN NAME: Jennie M. Baker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.War 1
16. SOCIAL SECURITY NO.: 212-12-3255
17. INFORMANT: Mrs. Edna Jones, Address: Millington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Rupture
DUE TO (b): Chronic Myocardial
DUE TO (c): Arterial Sclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4[illegible].1

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) W
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year ——— 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 1957 19[illegible] to March 5 1960 that I last saw the deceased alive on March 3 1960, and that death occurred at 5 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: C H Metcalfe M.D. ADDRESS (Street, city or town, state): Lutherville DATE SIGNED: Mar 3/7/60

PHYSICIAN'S NAME (Type): C. H. METCALFE

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 9, 1960
22c. NAME OF CEMETERY OR CREMATORY: Millington Cemetery
22d. LOCATION (City, town, or county) (State): Millington, Kent Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: [illegible] ington Md.
24a. REC'D BY REGISTRAR DATE MAR 9 '60
24b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3432 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03390

1. PLACE OF DEATH
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Betterton
c. LENGTH OF STAY IN 1b: 15 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Betterton
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Cornelia Middle A. Last Kettlewell

4. DATE OF DEATH: Month March Day 22 Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 26, 1886
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Harford Co. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Haviland
14. MOTHER'S MAIDEN NAME: Ellen M. Ford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Earl Haviland Address: 6808 Old Harford Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): T.C.4
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

Unknown, but probably natural causes. Manner of death appears to resemble cardiac death. Probably sudden Was last seen alive nite of 3/22/60. Was found dead in her home about 5:00 PM 3/22/60. Examination of body failed to disclose any evidence of cause of death but she had taken one floor beside her bed. She was in addition indicating she had been on it. There were no signs of injury

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Robt W. Farr M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: March 22, 1960

EXAMINER'S NAME (Type): Robert W. Farr

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 26, 1960
22c. NAME OF CEMETERY OR CREMATORY: Loudon Park
22d. LOCATION (City, town, or county) (State): Baltimore, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE: J. W. Meaderson ADDRESS: 805 N. Calvert Street
24a. REC'D BY REGISTRAR DATE: MAR 28 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

1

M

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be recorded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3433

Reg. Dist. No. 03391

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Golt
c. LENGTH OF STAY IN 1b: 3Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Golt
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: John Last: Miller

4. DATE OF DEATH: Month: March Day: 18 Year: 1960

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 17, 1885

9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): A.M.E. Minister

10b. KIND OF BUSINESS OR INDUSTRY: Church

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Sepio Miller

14. MOTHER'S MAIDEN NAME: No Record

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 220-34-6654

17. INFORMANT: Mrs. Wm. John Miller Address: Golts, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Unknown but probably natural causes — INTERVAL BETWEEN ONSET AND DEATH: don't know

DUE TO (b): Deceased had not been under care of a physician. He had not been apparently ill. Death occurred about 11:30 P.M. 3/18/60.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): '95.4

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☐, and find that death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☒

ACTUAL SIGNATURE: Robert W. Farr M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED

EXAMINER'S NAME (Type): Robert W. Farr, M. D. 3/22/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/28/60

22c. NAME OF CEMETERY OR CREMATORY: Golt Cemetery

22d LOCATION (City, town, or county) (State): Golt, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Tolliver ADDRESS: Millington, Md.

24a. REC'D BY REGISTRAR DATE: MAR 28 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Friend

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3422

CERTIFICATE OF DEATH

Reg. Dist. No. 03392

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Campus Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
d. STREET ADDRESS: Campus Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: Barwick — Last: Oliffe

4. DATE OF DEATH: Month: Mar. — Day: 1, — Year: 1960

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 10, 1908

9. AGE (In years last birthday): 51 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Andelot Farms

11. BIRTHPLACE (State or foreign country): Kent Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph B. Oliffe

14. MOTHER'S MAIDEN NAME: Rose Bowers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 222-20-2071

INFORMANT: Jos. B. Oliffe, Jr. — Address: Crumpton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 15 minutes

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1951, to Mar. 1, 60, that I last saw the deceased alive on Mar. 1, 1960, and that death occurred at 9:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert W. Farr M.D. — ADDRESS (Street, city or town, state): Chestertown, Md. — DATE SIGNED: 3/2/60

PHYSICIAN'S NAME (Type): Robert W. Farr

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Mar. 3, 1960

22c. NAME OF CEMETERY OR CREMATORY: Kennedyville Cem.

22d. LOCATION (City, town, or county) (State): Kennedyville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells — ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: MAR 3 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3423 **CERTIFICATE OF DEATH** 03393

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland b. COUNTY: Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 3 days
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Still Pond

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Anne's
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First John Middle Fletcher Last Price

4. DATE OF DEATH: Month 3 Day 7 Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: 10/3/83
9. AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S. of America

13. FATHER'S NAME: William B. Price
14. MOTHER'S MAIDEN NAME: Elizabeth WATTS ~~(last name unknown)~~.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: (none)
INFORMANT Address: Marie Price, Still Pond, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3-5-60

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerosis — Several yrs.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 3-4- , 1960, to 3-7- , 1960, that I last saw the deceased alive on 3-7- , 1960, and that death occurred at 9 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: A.C. Dick M.D.
ADDRESS (Street, city or town, state): Chestertown, Maryland
DATE SIGNED: 3-8-60

PHYSICIAN'S NAME (Type): A.C. Dick

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3-10-60
22c. NAME OF CEMETERY OR CREMATORY: STILL POND CEMTY
22d. LOCATION (City, town, or county) (State): STILL POND, MD

23. FUNERAL DIRECTOR'S SIGNATURE: Victor N. Kennedy
ADDRESS: STILL POND, MD.
24a. REC'D BY REGISTRAR DATE: MAR 9 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3424 **CERTIFICATE OF DEATH**

03394

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Anne Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XRural Chestertown
d. STREET ADDRESS: RFD
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First R. Middle Woodall Last Robinson

4. DATE OF DEATH: Month Mar. Day 13, Year 1960

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Feb. 11, 1881

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: owner

11. BIRTHPLACE (State or foreign country): Queen Anne Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William C. Robinson

14. MOTHER'S MAIDEN NAME: Martha Woodall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 220-34-9208

17. INFORMANT: Mrs. Woodall Robinson — Address: Chestertown, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 Days
DUE TO (b): Arteriosclerosis — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

4 20. 1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bleeding Peptic Ulcer 1 wk

19 WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/27 1960 to 3/13 1960, that (I) (we) last saw the deceased alive on 3/13 1960 and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: Thomas J Solon M.D. — ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 3/15/60

22c. PHYSICIAN'S NAME (Type): Thomas J. Solon

22d. ADDRESS: Chestertown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/16/60

23c. NAME OF CEMETERY OR CREMATORY: Crumpton Cemetery

23d. LOCATION (City, town, or county) (State): Crumpton, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells — ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: MAR 17 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3434

CERTIFICATE OF DEATH

Reg. Dist. No. 03395

1. PLACE OF DEATH a. COUNTY: Kent — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall (Edesville)

c. LENGTH OF STAY IN 1b: Life

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: At Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE: Maryland — b. COUNTY: Kent

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rock Hall

d. STREET ADDRESS: (Edesville)

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: A. — Last: Thompson

4. DATE OF DEATH: Month: Mar. — Day: 30, — Year: 1960

5. SEX: male

6. COLOR OR RACE: colored

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 4/9/1904

9. AGE (In years last birthday): 55 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Masonery

11. BIRTHPLACE (State or foreign country): Kent Co. Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Minnie Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT Address: Mrs. Ivory Warren Rock Hall, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

DUE TO (b): Coronary Sclerosis

DUE TO (c): Cerebral Ischemia

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from March 1, 1960, to March 30, 1960, that I last saw the deceased alive on March 29, 1960, and that death occurred at 6 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Norbert C Nitsch M.D. — ADDRESS (Street, city or town, state): Rock Hall, Md. — DATE SIGNED: 3/31/60

PHYSICIAN'S NAME (Type): Norbert C. Nitsch

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Apr. 2, 1960

22c. NAME OF CEMETERY OR CREMATORY: Sharptown Cem. near

22d. LOCATION (City, town, or county) (State): Rock Hall, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Kenneth Wallery — ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: APR 4 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospitol or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3425 **CERTIFICATE OF DEATH** 03396

Reg. Dist. No.

1 M

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 17 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Anne's

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 37 Chestertown
d. STREET ADDRESS: 351 High Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

072

3. NAME OF DECEASED (Type or print): First: William — Middle: Bullitt — Last: Vincent

4. DATE OF DEATH: Month: 3 — Day: 11 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/9/99

9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bus driver

10b. KIND OF BUSINESS OR INDUSTRY: Public Transportation

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.of America

13. FATHER'S NAME: Charles Vincent

14. MOTHER'S MAIDEN NAME: Emma Wallace

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214 10 8636

INFORMANT: Helen B. Vincent, wife — Address

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CARCINOMA OF PANCREAS — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

157X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 17, 1960, to MAR 11, 1960, that I last saw the deceased alive on MAR 11, 1960, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A. T. Keefe M.D. — ADDRESS (Street, city or town, state): Chestertown, Md — DATE SIGNED: 3.11.60

PHYSICIAN'S NAME (Type): Arthur T. Keefe, Jr., M. D., FACS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 3/13/60 — 22c. NAME OF CEMETERY OR CREMATORY: Chester Cem. — 22d. LOCATION (City, town, or county) (State): Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J Willis Wells — ADDRESS: Chestertown, Md. — 24a. REC'D BY REGISTRAR DATE: MAR 14 '60 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3435 — 03397 — Reg. Dist. No.

1. PLACE OF DEATH — a. COUNTY: Kent — MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Kent
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Chestertown
c. LENGTH OF STAY IN 1b: life
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural - Chestertown, Md.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): At home Morgnec
d. STREET ADDRESS: Morgnec
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: John — Middle: — Last: Wilson
4. DATE OF DEATH: Month: Mar. — Day: 4, — Year: 1960
5. SEX: male
6. COLOR OR RACE: colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Apr. 14, 1894
9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: owner
11. BIRTHPLACE (State or foreign country): Kent Co. Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Thomas R. Wilson
14. MOTHER'S MAIDEN NAME: Annie Naylor
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Don't know
17. INFORMANT: Elwood Wilson — Address: Bigwoods RFD Worton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Unknown but probably natural causes — INTERVAL BETWEEN ONSET AND DEATH:

795.5

DUE TO (b): Deceased had been well for many years. He was last seen alive the A.M. of 3/4/60 at which time he was

DUE TO (c): likewise in godd health, apparently. He was found dead in his home by a neighbor on the evening of 3/5/60. He is not known to have suffered from any illness nor had he consulted a physician for many years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Robert W. Farr M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 3/7/60

EXAMINER'S NAME (Type): Robert W. Farr

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/10/60
22c. NAME OF CEMETERY OR CREMATORY: Bigwoods Cem. RFD
22d. LOCATION (City, town, or county) (State): Worton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Kenneth Walker — ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR — DATE: MAR 11 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kinnamon

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5) 5M 9/55